Statement on PBM RFP

by Dudley Burdge

Today we have before the SHBC a proposal to begin the process for the state to directly contract for pharmacy benefits management.

It must be said -- finally! It's about time.

State worker unions have called for such a step since at least 2002. It's an important step towards oversight and cost control of what is an annual drug spend of over a half billion dollars.

A couple of items illustrate the current lack of oversight.

In 2 003, in preparation for collective bargaining negotiations that year, CWA requested of the state a copy of the contract governing the pharmacy benefit management services that are provided to the State Health Benefits Plan.

The state's chief negotiator said it would be no problem to provide the contract. It is now five years later and no one from CWA, the state's negotiating team, or the Division of Pensions and Benefits have seen the contract that has governed the state's purchase of billions of dollars worth of drugs.

That's because the contract is actually between Caremark (previously Advance PCS) and Horizon and it is said to be proprietary.

Likewise, this Commission, which has the responsibility of overseeing the drug purchase program and duty to restrain costs has never seen an audit of the drug program.

Currently, we don't have stand ing to demand such an audit. Imagine, our plan provides health care services to three quarters of a million people and spends well over a half billion dollars annually on drugs -- but we can't audit our purchase.

Further, this Commission has no idea of the fees charged by Caremark. We have received documents, through Aon consultants, that appear to indicate that Caremark charges no fees or negative fees. This seems like a pretty unlikely state of affairs for a profitable company like Caremark. The co-mingling of administrative fees and rebates effectively obscures what value the SHBC receives for our purchase.

It's just stunning -- no contract, no audit, no idea of what we are charged -- how can we possibly justify the current state of affairs to taxpayers?

The controversies surrounding our current provider of PBM services, Caremark, gives pause and leads to a strong suspicion that we are not receiving full value for our drug purchase.

There is even a well researched website at www.alarmedaboutcvscaremark.com that details the various legal actions taken by health plans, consumers, US Attorneys, and state Attorneys General against CVS Caremark.

Consider that in the past few years Caremark was forced to come to settlement agreements in many significant cases such as:

* 23 state settlement over charges of improper drug switching,
* a 28 state settlement over charges of deceptive practices,
* a $137 million US Department of Justice settlement of litigation con

cerning false claims.

In just the first six months of 2008, CVS Caremark paid over $75 million to settle lawsuits that included drug-switching claims. Consumer advocates have repeated accused Caremark of selling or sharing patient data.

Further, advocates state that secrecy in Caremark's business practices hinder accountability. Says the Alarmed About CVS Caremark Coalition: "although audits can expose costly errors or fraud by PBMs and reap big benefits for health plans, CVS Caremark limits plans' ability to conduct meaningful audits, allowing the Company to keep important information from plans, including drug pricing and the amount and source of fees and other revenue it receives from drug manufacturers...

CVS Caremark has even lost several major clients -- including the State of Illinois, the State of maryland and the University of Michigan -- in part because of its resistance to transparency." Just last year, SEPTA (the Southeastern Pennsylvania Transportation Authority sued Caremark over drug switching charges and SEPTA's inability to conduct an effect audit of the services provided to it by Caremark. In wooing SEPTA's business Caremark had promised SEPTA complete access to necessary data.

So there is a clear need for the state to contract directly for PBM services and ensure that we receive value for our dollars. The Division is to be saluted for this initiative.
There is great potential for cost containment in this initiative.

But it needs to be done carefully.

First a R FP needs to be carefully crafted and come back to the Commission for review and approval prior to release to bidders.

The Commission will need adequate time to review the complexities of the RFP.
It makes sense for the RFP to reflect these key values:

* *Full, real and easily accessible transparency*. We should know about all financial arrangements between a PBM and drug manufacturers, wholesalers, and others. Promises of transparency, which all PBMs now give, are not enough. We need comprehensive mechanisms to ensure transparency. What do drug companies receive in return for the rebates, educational fees and other fees paid to PBMs that provide such as important part of the margins of PBMs? Real audits are necessary to determine if the state gets value for its drug purchase.

* *We should not be seduced by the lure of high rebates on brand name drugs. Contracts should be administrative fee based.* Indeed most serious observers believe that concentration on receiving greater rebates actually has the potential to increase drug costs and reduce efficacy. Rebates are typically given by drug companies to encourage purchase of new more expensive drugs when generics or other brand drugs may both be less expensive and more clinically effective. Use of the most clinically effective and often less expensive drugs has a huge potential to lower drug costs. We should pay administrative fees so our PBM earns its profits from us and not from fee and rebate arrangements with drug manufacturers.

* *Evidence based information on the effectiveness of drugs should be made available to members and prescribers and should guide the development of the formulary for retirees.* The receipt of rebates and others fees from drug manufacturers by PBM and the development of formularies by the same PBM is natural conflict that contains the likelihood of increased costs for health plans like ours. Serious consideration should be given to making an arrangement independent of the general PBM contract to develop the formulary

* *Drug data should be used to buttress our disease management and wellness initiatives.* For instance, certain drug usage patterns could be an earlier warning sign of a disease state. Naturally, privacy must be protected in such programs.

Other items worthy of consideration by the drafters of the RFP include:

* Are there ways of joining with other NJ state drug purchasers and/or other states to achieve greater discounts?

* Mail order operations are normally profit centers for PBMs, how do we achieve the greatest value in mail order. Should the state contract for its own central fill facility?

* Indeed should there be multiple contracts fo r various PBM services rather than a single contract? For instance, should the group determining the formulary be separate from the group negotiating discounts?

* Are some drugs, for instance, seasonal allergy medicines now considered maintenance drugs which may lead to large quantities of drugs that are unused by patients?

* Does it make sense to pay for some over the counter drugs if the alternative is a prescription for a much more expensive but not more effective brand drug?

* How do we eliminate the drug spread, that is the difference between what PBMs often pay pharmacists and what the PBM charges a health plan?

* What are reasonable targets for gener ic drug usage and how would a PBM achieve those goals?

* How can pharmacists be incentivized to guide patients and physicians to evidence based and effective drugs?

Finally, a word needs to be said about the consultants to those putting together the RFP -- Aon Consultants. Aon has multiple interrelations with the PBM industry. For instance, Aon partners with PBMs to provide products for health plans and individuals. Further, PBMs contract with Aon (and other health consultants for actuarial services.

We need to know about all of these relationships to properly place the information and opinions that Aon provides in context.

December 11, 2008